Effective Date: April 14, 2003

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES, OFFICE OF MANAGED CARE

Los Angeles County Department of Health Services
Community Health Plan
Notice of Privacy Practices for Medi-Cal Patients

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

WHO WILL FOLLOW THIS NOTICE

This Notice describes the practices of Los Angeles County Department of Health Services ("LACDHS") Community Health Plan and that of all employees, staff and other personnel.

OUR PLEDGE REGARDING YOUR MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the health care claims reimbursed under the Community Health Plan for administration purposes. We need this record to provide you with quality service and to comply with certain legal requirements. This Notice applies to all of the medical records we maintain. As required and when appropriate, we will ensure that the minimum necessary information is released in the course of our duties.

This Notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations regarding the use and disclosure of medical information.

We are required by law to:

- Keep your medical information, also known as "protected health information" or "PHI," private;
- Give you this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Notice that is currently in effect.

*******ATTENTION*******
This Notice and interpreters are available in your own language. Please contact the COMMUNITY HEALTH PLAN at toll-free 1(800) 475-5550 for a copy.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment

We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose your PHI to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a new prescription is compatible with your other medication.

For Payment

We may use and disclose your PHI to determine eligibility for Community Health Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Community Health Plan, or to coordinate the Community Health Plan coverage. For example, we may use information that your doctor submits about an office visit to determine whether the fee for the office visit should be paid under the Community Health Plan.

For Health Care Operations

We may use and disclose your PHI to carry out activities that are necessary to run the Community Health Plan and to make sure that all of our participants receive quality services. For example, we may use or disclose health information to review the quality of care provided by our network of health care providers.

Treatment Alternatives and Health-Related Products and Services

We may use and disclose your PHI to recommend possible treatment options or alternatives that may be of interest to you. Additionally, we may use and disclose PHI to tell you about health-related benefits or services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care

We may disclose your PHI to a friend or family member who is involved in your medical care or payment related to your health care, provided that you agree to this disclosure, or we give you an opportunity to object to this disclosure. However, if you are not available or are unable to agree or object, we will use our professional judgment to decide whether this disclosure is in your best interests.

Disaster Relief Purposes

We may disclose your PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location. We will give you the opportunity to agree to this disclosure or object to this disclosure, unless we decide that we need to disclose your PHI in order to respond to the emergency circumstances.

As Required By Law

We will disclose your PHI when required to do so by federal, state or local law.

Health Oversight Activities

We may disclose your PHI to a health oversight agency for activities authorized by law. For example, we may disclose your information to authorized persons in the Medi-Cal program who need to monitor the Medi-Cal program or to the federal government for checking our compliance with the privacy rules.

Lawsuits and Disputes

If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We will not share your information if the Medi-Cal program would not allow it.

Law Enforcement

We may disclose PHI to government law enforcement agencies in response to a court order, warrant, subpoena, summons or similar process issued by a court. We will not share your information if the Medi-Cal program would not allow it.

Other Uses of Your Medical Information

Other uses and disclosures of your PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your PHI, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your PHI for the reasons covered by the authorization, except that, we are unable to take back any disclosures we have already made when the authorization was in effect, and we are required to retain our records of the services that we provided to you.

RIGHTS REGARDING YOUR PHI

You have the following rights regarding your PHI in our records:

Right to Inspect and Copy

With certain exceptions, you have the right to inspect and copy your PHI that may be used to make decisions about your Community Health Plan benefits.

To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing. A form will be provided to you for this request. If you request a copy of your PHI, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

We may deny your request to inspect and copy in certain circumstances. If you are denied the right to inspect and copy your PHI in our records, you may request that the denial be reviewed. With the exception of a few circumstances that are not subject to review, another licensed health care professional within the Community Health Plan's Provider Network, who was not involved in the denial, will review the decision. We will comply with the outcome of the review.

********IMPORTANT********

The COMMUNITY HEALTH PLAN does not have complete copies of your medical records. If you want to look at, get a copy, or change your medical records, please contact your doctor or clinic.

Right to Request Amendment

If you feel that your PHI in our records is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the PHI. To request an amendment, ask for a *Request to Amend Protected Health Information* form, and complete and submit this form to the Community Health Plan contact listed in this Notice. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend PHI that:

- Was not created by us, unless you can provide us with a reasonable basis to believe that the person or entity that created the PHI is no longer available to make the amendment;
- Is not part of the PHI kept by or for the Community Health Plan;
- Is not part of the PHI which you would be permitted to inspect and copy; or
- Is accurate and complete.

Even if we deny your request for amendment, you have the right to submit a *Request for Review of Denial of Access* form, with a description not to exceed 250 words, with respect to any item or statement in your record you believe is incomplete or incorrect. If you clearly indicate in writing that you want this form to be made part of your medical record, we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe to be incomplete or incorrect.

Right to an Accounting of Disclosures

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your PHI other than our own uses for treatment, payment and health care operations, (as those functions are described above) and with other exceptions pursuant to the law.

To request this list or accounting of disclosures, ask for a *Request for an Accounting of Disclosures* form, and complete and submit this form to the Plan contact listed in this Notice. Your request must state a time period that

may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions

You have the right to request that we follow additional, special restrictions when using or disclosing your PHI for treatment, payment or health care operations. You also have the right to request that we follow additional, special restrictions when using or disclosing your PHI to someone who is involved in your care or the payment for your health care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

To request restrictions, ask for a *Request for Additional Restrictions on Use or Disclosure of Protected Health Information*, and complete and submit this form to the Community Health Plan contact listed in this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications

You have the right to request that we communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, ask for a *Request to Receive Confidential Communications by Alternative Means or at Alternative Locations* form, and complete and submit this for to the person in charge of your treatment. Your request must specify how or where you wish to be contacted. We will not ask you the reason for your request. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Copies of this Notice are available upon request. Please contact the COMMUNITY HEALTH PLAN at toll-free 1(800) 475-5550 for a copy.

You may also obtain a copy of this notice at our website, http://www.ladhs.org/chp

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice on our website, http://www.ladhs.org/chp. The Notice will contain on the first page, in the top right-hand corner, the effective date. If there is a material revision to this notice, we will post or distribute a copy to Community Health Plan participants within 60 days after the revision is made. At least every three years, the Community Health Plan will notify current Community Health Plan participants of the availability of the Notice and how to obtain the Notice.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with Los Angeles County or the Federal Government. All complaints must be submitted in writing. **You will not be penalized or retaliated against for filing a complaint.** To file a complaint, contact any of the following offices:

To file a complaint with Los Angeles County, contact:

Los Angeles County Department of Health Services

Privacy Officer

313 N. Figueroa Street, Room 708

Los Angeles, CA 90012

(800) 711-5366

Los Angeles County Chief Information Office
Chief Information Privacy Officer
500 West Temple Street, Suite 493
Los Angeles, CA 90012
(213) 974-2164
Email: CIPO@cio.co.la.ca.us

To file a complaint with the Federal Government, contact:

Office of Civil Rights (Room 515 F)
US Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
(866) 627-7748 or (866) 788-4989 TTY

QUESTIONS?

If you have any questions about this Notice or want further information regarding our privacy practices, please contact the COMMUNITY HEALTH PLAN at toll-free 1(800) 475-5550.